Washington State Health Care Authority
Public Employees Benefits Board

Clear Form

2015 Employee Enrollment/Change

- **Type or print clearly in black ink.** Inaccurate, incomplete, or illegible information may delay coverage.
- **List eligible family members you wish to cover or remove from coverage. This form replaces all *Employee Enrollment/ Change* forms previously submitted.**

Subscriber's last name	First name	Middle initial	Social Security number

Are you making changes to an existing account?

☐ **Yes** **If yes, what changes?** *(Check all that apply in the sections below.)*

☐ **No** *(If no, go to Section 1.)*

Changes you can make anytime

Give date of event/change _____

☐ Name change ☐ Address change ☐ Submit a change to a premium surcharge attestation

☐ Remove dependent(s) from coverage due to loss of eligibility (divorce, dissolution of registered domestic partnership, death, or other loss of eligibility for PEBB benefits). **Your benefits office must receive this form no later than 60 days after the event.** If applicable, provide former dependent's new address:

_____

Additional changes you can make during the PEBB Program's annual open enrollment

All changes become effective January 1 of the following year.

Check the box(es) next to the change requested.

☐ Add dependent(s) ☐ Change dental plan

☐ Remove dependent(s) ☐ Enroll after waiving medical coverage

☐ Change medical plan ☐ Waive medical coverage due to enrollment in other employer-based group medical insurance

Additional changes you can make if an event creates a special open enrollment

The PEBB Program only allows changes outside of an annual open enrollment when an event creates a special open enrollment. The change must be allowable under Internal Revenue Code and correspond to and be consistent with a special open enrollment event for the subscriber, the subscriber's dependent, or both. You are required to provide proof of the event that created the special open enrollment. **Your benefits office must receive this form and proof of the event no later than 60 days after the event.** However, if adding a newborn or newly adopted child increases your premium, you must submit this form no later than 12 months after the birth or adoption.

Check the box next to each change you are requesting and indicate the corresponding event(s) on the following page. In most cases, the enrollment or change will be effective the first day of the month after the event date or the date the form is received, whichever is later.

☐ **Add dependent(s)** (allowable under events 1, 2, 3, 4, 5, 6, 7, 9, 10, 11)

☐ **Enroll after waiving medical coverage** (allowable under events 1, 2, 3, 4, 5, 6, 7, 9, 10, 11)

☐ **Change medical plan** (allowable under events 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 13, 14)

☐ **Change dental plan** (allowable under events 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 13, 14)

☐ **Remove dependent(s)** (allowable under events 1, 5, 6, 9, 10)

☐ **Waive medical coverage due to enrollment in other employer-based group medical insurance** (allowable under events 1, 5, 6, 9, 10)

Give date of event _____

(this section continued on next page)

Agency name	Agency/subagency	Insurance effective date	Hire date

Subscriber's last name	First name	Middle initial	Social Security number

Additional changes you can make if an event creates a special open enrollment

(continued from previous page)

Check the box(es) next to the corresponding event(s). The event number below must be listed next to the change(s) you are requesting on the previous page.

- ☐ 1. Marriage, registering a domestic partner, as defined by Washington Administrative Code 182-12-260(2), birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption. Also complete a *Declaration of Tax Status* form if adding a registered domestic partner and/or his or her eligible children.
- ☐ 2. Child becoming eligible as an extended dependent through legal custody or legal guardianship. Also complete an *Extended Dependent Certification* form.
- ☐ 3. Child becoming eligible as a dependent with a disability. Also complete a *Certification of Dependent With a Disability* form.
- ☐ 4. Employee or dependent losing other coverage under a group health plan or through health insurance, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- ☐ 5. Employee or dependent having a change in employment status that affects the employee's or dependent's eligibility for their employer contribution toward employer-based group health insurance.
- ☐ 6. Employee or dependent having a change in enrollment under another employer-based group health insurance during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.
- ☐ 7. Employee's dependent moving from outside the United States to live within the United States or moving from inside the United States to live outside the United States.
- ☐ 8. Employee or dependent having a change in residence that affects health plan availability.
- ☐ 9. A court order or National Medical Support Notice requiring the employee or any other individual to provide insurance coverage for an eligible dependent of the employee.
- ☐ 10. Employee or a dependent becoming entitled to or losing eligibility for Medicaid or a state Children's Health Insurance Program (CHIP).
- ☐ 11. Employee or dependent becoming eligible for a state premium assistance subsidy for PEBB health coverage from Medicaid or a state Children's Health Insurance Program (CHIP).
- ☐ 12. Employee or dependent becoming entitled to or losing eligibility for Medicare, or enrolling in or cancelling enrollment in a Medicare Part D plan.
- ☐ 13. Employee's or dependent's current health plan becoming unavailable because the employee or dependent is no longer eligible for a health savings account (HSA).
- ☐ 14. Employee or dependent experiencing a disruption of care that could function as a reduction in benefits for the employee or his or her dependent for a specific condition or ongoing course of treatment (requires approval by the PEBB Program).

Forms available at **www.hca.wa.gov/pebb**.

Are you or any eligible dependents already enrolled in PEBB coverage under another account? ☐ **Yes** ☐ **No**

If yes, please contact your personnel, payroll, or benefits office for assistance.

(continued)

2015 Employee Enrollment/Change

Section 1: Subscriber Information

Social Security number	Last name	First name	Middle initial	Sex ☐ M ☐ F

Street address	Apt./unit number	City	State	ZIP Code
Mailing address (if different from above)	Apt./unit number	City	State	ZIP Code

County of residence	Date of birth (mm/dd/yyyy)	Work phone number	Home phone number

Medical coverage ☐ Cover ☐ Waive: effective date _____

If waiving, see Section 6. **Note:** If you waive coverage, you must be enrolled in other employer-based group medical insurance. You cannot enroll your eligible dependents in medical.

Dental coverage ☒ Cover (Dental may not be waived.)

Tobacco Use Premium Surcharge

The PEBB Program requires a monthly $25 surcharge in addition to your premium if you or a family member you enroll on your PEBB medical coverage uses a tobacco product. Tobacco use is defined as any use of tobacco products within the past two months except for religious or ceremonial use. If you check YES or leave the check boxes blank you will pay the $25 surcharge. See the *2015 Premium Surcharge Help Sheet* for instructions on how to respond.

Does the tobacco use premium surcharge apply to you? Check one:

☐ I previously attested to the tobacco use premium surcharge and my attestation has not changed.
☐ YES, I have used tobacco products in the past two months.
☐ NO, or I have used the tobacco cessation resources noted in the *2015 Premium Surcharge Help Sheet*.

Section 2: Spouse or Registered Domestic Partner Information

- List an eligible spouse or registered domestic partner, as defined by Washington Administrative Code 182-12-260(2), you wish to cover or remove from coverage.
- You may skip this section if you are not enrolling a spouse or registered domestic partner.
- Family members cannot be enrolled in two PEBB medical or dental accounts at the same time.
- If adding a spouse or registered domestic partner, you must provide proof of eligibility within PEBB's enrollment timelines or the spouse or registered domestic partner will not be enrolled.
- Forms and a list of documents we will accept to verify eligibility are available at **www.hca.wa.gov/pebb .**

Relationship to subscriber
(If adding a registered domestic partner, please attach a completed *Declaration of Tax Status* form.)

☐ Spouse: date of marriage _____ ☐ Registered domestic partner: date registered _____

Social Security number	Last name	First name	Middle initial	Sex ☐ M ☐ F

Street address (only if different from subscriber) Apt./unit number	City	State	ZIP Code

Date of birth (mm/dd/yyyy)	

Medical coverage ☐ Cover
☐ Remove from medical coverage Reason _____

Dental coverage ☐ Cover
☐ Remove from dental coverage Reason _____

Tobacco Use Premium Surcharge

Does the tobacco use premium surcharge apply to your spouse or registered domestic partner? Check one:

☐ I previously attested to my spouse's or registered domestic partner's tobacco use and the attestation has not changed.
☐ YES, my spouse or registered domestic partner has used tobacco products in the past two months.
☐ NO, or my spouse or registered domestic partner has used the tobacco cessation resources noted in the *2015 Premium Surcharge Help Sheet*.

(continued)

Subscriber's last name	First name	Middle initial	Social Security number

Section 2: Spouse or Registered Domestic Partner Information *(continued from previous page)*

Spouse or Registered Domestic Partner Coverage Premium Surcharge

The PEBB Program requires a monthly $50 surcharge in addition to your premium if your spouse or registered domestic partner has **chosen** not to enroll in other employer-based group medical insurance that is comparable to Uniform Medical Plan Classic. See the *2015 Premium Surcharge Help Sheet* for instructions on how to respond. If you check YES below or leave this section blank, you will pay the monthly surcharge.

Does the spouse or registered domestic partner coverage surcharge apply to you? Check one:

- ☐ I previously attested to the spouse or registered domestic partner coverage premium surcharge for 2015 and the attestation has not changed.
- ☐ YES, I used the *2015 Premium Surcharge Help Sheet* and completed the *2015 Spousal Plan Calculator* online.
- ☐ NO, I used the *2015 Premium Surcharge Help Sheet* and, if needed, completed the *2015 Spousal Plan Calculator* online.

Which questions, if any, on the *2015 Premium Surcharge Help Sheet* did you check NO? Check all that apply.

☐ Question 1 ☐ Question 2 ☐ Question 3 ☐ Question 4 ☐ Question 5 ☐ Question 6

- ☐ Employer to determine. I used the *2015 Premium Surcharge Help Sheet* and am completing and submitting a printed *2015 Spousal Plan Calculator*. My employer will determine whether my spouse's or registered domestic partner's employer-based group medical insurance is comparable to UMP Classic.

The *2015 Premium Surcharge Help Sheet* and the *2015 Spousal Calculator* are available at **www.hca.wa.gov.pebb**.

Section 3: Family Member Information (such as a child) ***Use additional forms for more members.***

- You may skip this section if you are not enrolling additional family members.
- List eligible family members you wish to cover or remove from coverage.
- Family members cannot be enrolled in two PEBB medical or dental accounts at the same time.
- If adding a family member, you must provide proof of eligibility for each family member within PEBB's enrollment timelines or the family member will not be enrolled. If adding a child of your registered domestic partner, also attach a *Declaration of Tax Status form*.
- If enrolling a dependent with a disability age 26 or older, or an extended dependent, defined by Washington Administrative Code 182-12-260, submit the appropriate dependent certification form(s) as instructed on the form. Refer to the *Employee Enrollment Guide* for eligibility information.
- Forms and a list of documents we will accept to verify eligibility are available at **www.hca.wa.gov/pebb.**

A	**Relationship to subscriber**	*Check only if age 26 or older.* Disabled? ☐ Yes ☐ No	Extended dependent validated by court order? ☐ Yes ☐ No	Social Security number

Last name	First name	Middle initial	Sex ☐ M ☐ F	Date of birth (mm/dd/yyyy)

Street address (only if different from subscriber) Apt./unit number	City	State	ZIP Code

Medical coverage ☐ Cover ☐ Remove from medical coverage Reason _____

Dental coverage ☐ Cover ☐ Remove from dental coverage Reason _____

Tobacco Use Premium Surcharge

Does the tobacco use premium surcharge apply to this family member? (Response required regardless of age.) Check one:

- ☐ I previously attested to this family member's tobacco use and the attestation has not changed.
- ☐ YES, this family member has used tobacco products in the past two months.
- ☐ NO, or this family member has used the tobacco cessation resources noted in the *2015 Premium Surcharge Help Sheet*.

(continued)

2015 Employee Enrollment/Change

Subscriber's last name	First name	Middle initial	Social Security number

B **Relationship to subscriber** | *Check only if age 26 or older.* Disabled? ☐ Yes ☐ No | Extended dependent validated by court order? ☐ Yes ☐ No | Social Security number

Last name	First name	Middle initial	Sex ☐ M ☐ F	Date of birth (mm/dd/yyyy)

Street address (only if different from subscriber) Apt./unit number	City	State	ZIP Code

Medical coverage ☐ Cover ☐ Remove from medical coverage Reason _____

Dental coverage ☐ Cover ☐ Remove from dental coverage Reason _____

Tobacco Use Premium Surcharge

Does the tobacco use premium surcharge apply to this family member? (Response required regardless of age.) Check one:

☐ I previously attested to this family member's tobacco use and the attestation has not changed.
☐ YES, this family member has used tobacco products in the past two months.
☐ NO, or this family member has used the tobacco cessation resources noted in the *2015 Premium Surcharge Help Sheet*.

C **Relationship to subscriber** | *Check only if age 26 or older.* Disabled? ☐ Yes ☐ No | Extended dependent validated by court order? ☐ Yes ☐ No | Social Security number

Last name	First name	Middle initial	Sex ☐ M ☐ F	Date of birth (mm/dd/yyyy)

Street address (only if different from subscriber) Apt./unit number	City	State	ZIP Code

Medical coverage ☐ Cover ☐ Remove from medical coverage Reason _____

Dental coverage ☐ Cover ☐ Remove from dental coverage Reason _____

Tobacco Use Premium Surcharge

Does the tobacco use premium surcharge apply to this family member? (Response required regardless of age.) Check one:

☐ I previously attested to this family member's tobacco use and the attestation has not changed.
☐ YES, this family member has used tobacco products in the past two months.
☐ NO, or this family member has used the tobacco cessation resources noted in the *2015 Premium Surcharge Help Sheet*.

D **Relationship to subscriber** | *Check only if age 26 or older.* Disabled? ☐ Yes ☐ No | Extended dependent validated by court order? ☐ Yes ☐ No | Social Security number

Last name	First name	Middle initial	Sex ☐ M ☐ F	Date of birth (mm/dd/yyyy)

Street address (only if different from subscriber) Apt./unit number	City	State	ZIP Code

Medical coverage ☐ Cover ☐ Remove from medical coverage Reason _____

Dental coverage ☐ Cover ☐ Remove from dental coverage Reason _____

Tobacco Use Premium Surcharge

Does the tobacco use premium surcharge apply to this family member? (Response required regardless of age.) Check one:

☐ I previously attested to this family member's tobacco use and the attestation has not changed.
☐ YES, this family member has used tobacco products in the past two months.
☐ NO, or this family member has used the tobacco cessation resources noted in the *2015 Premium Surcharge Help Sheet*.

(continued)

Subscriber's last name	First name	Middle initial	Social Security number

Section 4: Medical Plan Selection *Check only one.*

Contact the plans for benefits information; their contact information is at the end of this form.

Group Health Cooperative

- ☐ Group Health Classic
- ☐ Group Health Value

Group Health Options Inc.

- ☐ Group Health Consumer-Directed Health Plan

Kaiser Foundation Health Plan of the Northwest

- ☐ Kaiser Permanente Classic
- ☐ Kaiser Permanente Consumer-Directed Health Plan

Uniform Medical Plan, administered by Regence BlueShield

- ☐ UMP Classic
- ☐ UMP Consumer-Directed Health Plan

Section 5: Dental Plan Selection *Check only one.*

Contact the plans for benefits information; their contact information is located at the end of this form.

Preferred Provider Organization

☐ Uniform Dental Plan, administered by Delta Dental of Washington (Group #3000)
(You may receive services from any provider.)

Managed-Care Plans

You must choose a provider from the dental plan network. Before you select a managed-care plan, be sure to call the dental plan to verify your provider is in their network and fill in the requested information below.

☐ DeltaCare, administered by Delta Dental of Washington (Group #3100)
Call DeltaCare at 1-800-650-1583 to verify your provider is in their network.

Dentist name or clinic code

_____

(You must receive services from a DeltaCare network provider.)

☐ Willamette Dental of Washington, Inc.

Clinic location

_____

(You must receive services from a Willamette Dental Group plan provider.)

Please sign and date this form on the next page.

(continued)

2015 Employee Enrollment/Change

Subscriber's last name	First name	Middle initial	Social Security number

Section 6: Signature *Required*

By signing this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB rules, to the extent permitted by federal and state laws, I must repay any claims paid by my health plan(s) or premiums paid on my behalf. My family members and I may also lose PEBB benefits as of the last day of the month we were eligible. To the extent permitted by law, PEBB or my employer may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not fully pay premiums when due. In addition, I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, denial of PEBB benefits, and loss of my job.

If adding a registered domestic partner to my account, I declare that my domestic partner and I have registered through the Washington Secretary of State's Office or another state.

Enrollment is not complete until verification of the family member's eligibility is successful. I understand that if I'm applying to add a dependent to my PEBB coverage, I must provide copies of documents that verify the dependent's eligibility within PEBB's enrollment timelines, or the dependent will not be enrolled.

Employees must enroll in PEBB dental, basic life, and basic long-term disability insurance. However, employees may waive PEBB medical if they are enrolled in other employer-based group medical insurance. If I waive medical, I understand I can enroll during the annual open enrollment period or within **60 days** of a special open enrollment event as defined in PEBB rules. If I waive medical for myself, I cannot enroll my eligible family members in medical.

I allow my employer to deduct money from my earnings to pay for insurance coverage and any applicable surcharges.

If I am enrolling in a consumer-directed health plan with a health savings account (HSA), I must meet HSA eligibility conditions. I understand that my employer will contribute to an HSA on my behalf based on the information I have provided, and that there are limits to these contributions and my HSA contributions (if any) under federal tax law.

I understand that if I am enrolled in PEBB retiree health coverage, I am choosing to defer that coverage for myself and any enrolled family members effective on my eligibility date for PEBB employee health coverage. I also understand if I am enrolled in retiree life insurance, I may keep it by completing and submitting the *Employee Life and AD&D Insurance Enrollment/Change Form* and having the premiums deducted from my paycheck.

This form replaces all *Employee Enrollment/Change* forms previously submitted.

HCA's Privacy Notice: We will keep your information private as allowed by law.
To see our Privacy Notice, go to **www.hca.wa.gov/pebb.**

Subscriber's signature _____ **Date** _____

Please sign and date this form.
Return completed form and documentation to your personnel, payroll, or benefits office.

2015 PEBB Medical Contractors

Group Health Cooperative
320 Westlake Ave. N., Suite 100, Seattle, WA 98109-5233
1-888-901-4636 or TTY 1-800-833-6388

Group Health Options Inc.
320 Westlake Ave. N, Suite 100, Seattle, WA 98109-5233
1-888-901-4636 or TTY 1-800-833-6388

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100, Portland, OR 97232-2099
1-800-813-2000 or TTY 711

Uniform Medical Plan, administered by Regence BlueShield
1800 Ninth Avenue, Suite 235, Seattle, WA 98101
1-888-849-3681 or TTY 711

2015 PEBB Dental Contractors

DeltaCare, administered by
Delta Dental of Washington
9706 Fourth Avenue NE, Seattle, WA 98115-2157
1-800-650-1583

Uniform Dental Plan, administered by
Delta Dental of Washington
9706 Fourth Avenue NE, Seattle, WA 98115-2157
1-800-537-3406

Willamette Dental of Washington, Inc.
6950 NE Campus Way, Hillsboro, OR 97124-5611
1-855-4DENTAL (1-855-433-6825)